

FOR OFFICE USE ONLY:

Date signed _____

Received _____

Docket Number _____

**VERMONT DEPARTMENT OF HEALTH
BOARD OF MEDICAL PRACTICE
108 Cherry Street, PO Box 70
Burlington VT 05402-0070
(802) 657-4220 or 800-745-7371**

COMPLAINT FORM**Please Print**

Your information

Last name _____ First name _____

Street address _____

City, State, Zip code _____

Business/daytime phone _____ Home phone _____

This is a complaint against a _____ Physician (MD)
_____ Physician Assistant (PA) or Anesthesiologist Assistant (AA)
_____ Podiatrist (DPM)

Full name of Physician, Physician's Assistant, Anesthesiologist Assistant or Podiatrist

Address _____

City, State, Zip code _____

Business phone of Physician, Physician's Assistant or Podiatrist _____

Name and location of health care facility (if known) _____

NATURE OF COMPLAINT: Please describe, in detail, the nature of your complaint against this practitioner. Use the space on the reverse and additional sheets, if necessary.

Please turn over and complete other side

Continue your complaint here _____

Attach copies of any materials you may have that will help us investigate your complaint, such as medical, pharmacy, or insurance records.

We need the signed release (enclosed) to investigate your complaint. We will send you a letter assigning a Docket Number to your case when we receive your signed Complaint Form and Authorization for Release of Medical Records.

Please note that a copy of this complaint and any information attached to it may be sent to the professional who is the subject of this complaint. If the complaint leads to formal discipline against the professional, the name and other information about the person filing the complaint may become public. Please call us if you have any questions.

Your Signature

Today's Date _____

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